MAXIMUS Federal Services

Case Number:	CM14-0071932		
Date Assigned:	08/08/2014	Date of Injury:	12/07/2001
Decision Date:	09/22/2014	UR Denial Date:	04/19/2014
Priority:	Standard	Application Received:	05/19/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Tennessee. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 54-year-old male who has submitted a claim for status post lumbar fusion surgery, gastritis, chronic pain syndrome, left total hip replacement in 2008, right knee arthroscopy in 2006, left knee arthroscopy, osteoarthritis, anxiety, depression, lower extremity radiculopathy, chronic severe bilateral hip pain, left hip revision surgery in 2013, and insomnia associated with an industrial injury date of 12/7/2001. Medical records from 2009 - 2014 were reviewed. Patient complained of worsening pain at the right hip status post revision arthroplasty. Pain was present even at rest, and aggravated during standing and walking. Patient likewise complained of constant low back pain, rated 7/10, radiating to bilateral lower extremities. Patient reported weakness, numbness and tingling sensation. Physical examination of the lumbar spine showed restricted range of motion. Straight leg raise test was positive bilaterally. Bilateral hip flexors were graded 4/5 in motor testing. Patient ambulated using a single-point cane. Sensation was intact. Treatment to date has included left total hip arthroplasty, physical therapy, right total hip arthroplasty in 2010, lumbar fusion surgery, and medications such as Lyrica, Senna, Percocet (since 2013), Fentanyl patch (since 2013), Prilosec, Lidoderm patch, and topical creams. Utilization review from 4/19/2014 denied the request for 8 sessions of Physical Therapy due to lack of documented functional improvement from previous visits; denied Fentanyl patch 100 mcg, #10 due to lack of sustained functional improvement from its use; denied Flurbiprofen 20% cream, 120gm, Ketoprofen 20%, ketamine 10% cream, 120gm, and Gabapentin 10%, Cyclobenzaprine 10% Capsaicin 0.0375% cream, 120gm due to lack of published studies concerning its efficacy and safety; and denied Percocet 10/325mg, #120 because of no significant subjective and objective improvements from its long-term use.Medical records from 2009 - 2014 were reviewed. Patient complained of worsening pain at the right hip status post revision arthroplasty. Pain was present even at rest, and aggravated during standing and

walking. Patient likewise complained of constant low back pain, rated 7/10, radiating to bilateral lower extremities. Patient reported weakness, numbness and tingling sensation. Physical examination of the lumbar spine showed restricted range of motion. Straight leg raise test was positive bilaterally. Bilateral hip flexors were graded 4/5 in motor testing. Patient ambulated using a single-point cane. Sensation was intact. Treatment to date has included left total hip arthroplasty, physical therapy, right total hip arthroplasty in 2010, lumbar fusion surgery, and medications such as Lyrica, Senna, Percocet (since 2013), Fentanyl patch (since 2013), Prilosec, Lidoderm patch, and topical creams.Utilization review from 4/19/2014 denied the request for 8 sessions of physical therapy due to lack of documented functional improvement from previous visits; denied Fentanyl patch 100 mcg, #10 due to lack of sustained functional improvement from its use; denied Flurbiprofen 20% cream, 120gm, Ketoprofen 20%, ketamine 10% cream, 120gm, and Gabapentin 10%, cyclobenzaprine 10% capsaicin 0.0375% cream, 120gm due to lack of published studies concerning its efficacy and safety; and denied Percocet 10/325mg, #120 because of no significant subjective and objective improvements from its long-term use.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

8 physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, patient completed a course of Physical Therapy in the past. However, the total number of sessions attended and patient's response to treatment were not discussed. There was no objective evidence of overall functional gains derived from the treatment. Given the duration of injury, it is unclear why patient is still not versed to home exercise program to address the residual deficits. Moreover, there were no recent reports of acute exacerbation or progression of symptoms that would warrant additional course of treatment. The medical necessity has not been established. Lastly, the request failed to specify body part to be treated. Therefore, the request for 8 Physical Therapy sessions is not medically necessary.

Fentanyl patch 100mcg #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl (transdermal), Duragesic Page(s): 93, 44.

Decision rationale: Page 44 of CA MTUS Chronic Pain Medical Treatment Guidelines states that "Duragesic (fentanyl transdermal system) is not recommended as a first-line therapy. Furthermore, page 93 also states that Duragesic is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy that cannot be managed by other means (e.g., NSAIDS). In this case, patient has been on Fentanyl patch since 2013. However, there was no documentation concerning pain relief and functional improvement derived from its use. The medical necessity cannot be established due to insufficient information. Therefore, the request for Fentanyl patch 100mcg #10 is not medically necessary.

Flurbiprofen 20% cream, 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. In addition, there is little to no research as for the use of Flurbiprofen in compounded products. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains Flurbiprofen that is not recommended for topical use. There is no discussion concerning need for variance from the guidelines. Therefore, the request for Flurbiprofen 20% cream, 120gm is not medically necessary.

Ketoprofen 20%, ketamine 10% cream, 120gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. Ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains Ketoprofen that is not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. There is likewise no discussion of failure of first-line therapy to warrant Ketamine in topical formulation. Therefore, the request for Ketoprofen 20%, Ketamine 10% cream, 120gm is not medically necessary.

Gabapentin 10%, cyclobenzaprine 10% capsaicin 0.0375% cream, 120gm:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical Analgesics Page(s): 28-29, 111-113.

Decision rationale: As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. CA MTUS does not support the use of opioid medications and Gabapentin in a topical formulation. Cyclobenzaprine is not recommended for use as a topical analgesic. CA MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option if there was failure to respond or intolerance to other treatments. The guideline states there is no current indication that an increase over a 0.025% formulation of Capsaicin would provide any further efficacy. In this case, topical cream is prescribed as adjuvant therapy to oral medications. However, the prescribed medication contains Gabapentin, Cyclobenzaprine, and Capsaicin 0.0375% that are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Gabapentin 10%, Cyclobenzaprine 10% Capsaicin 0.0375% cream, 120gm is not medically necessary.

Percocet 10/325mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Percocet since 2013. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Percocet 10/325mg, #120 is not medically necessary.